Medicaid Overview – Impact of House Ways and Means Committee Recommendations

Prepared by the South Carolina Department of Health and Human Services

March 6, 2002

This report may be viewed and downloaded by going to this internet address:
www.dhhs.state.sc.us

MEDICAID OVERVIEW

- Health care insurance for poor children, families, elderly and disabled.
- 44% of all children
- 2/3 of all nursing home beds
- 11,000 elderly and disabled covered by adult day care/meals on wheels.
- Elderly who earn up to @ $9,000 can receive prescription drugs.
- Certain services mandatory
  - Hospitalization
  - Physician Services
- Certain populations mandatory
  - Supplemental Security Income
  - Pre-school children up to 133% of poverty level
  - School age children up to 100% of poverty
  - Low income families (adults who have children) up to 50% of poverty level
- Optional Services
  - Pharmacy program
  - Adult day care/meals on wheels
- Optional Populations
  - Pre-school children between 133 and 150% of poverty level/CHIP kids
  - School age children between 100% and 150% if poverty
  - Aged, blind and disabled up to 100% of poverty level
- Reductions must come from optional services and optional populations.

Ways and Means Recommendation

DHHS presented a budget request of $185 million to House Ways and Means Committee. This request included no restoration of the mid-year 4% cut, no request for program or eligibility expansion, and no requests for provider rate increases. As best we can determine, the Ways and Means budget proposal grants DHHS @ $57 million of its request in appropriated dollars. The W&M budget does include monies to restore several items related to the 4% reduction. These include:

Restoration of the reduction to pharmacists;
Restoration of the reductions to physicians related to crossover payments;
An increase for physician payment rates;
Restoration of the durable medical equipment rate reduction;
Restoration of the nursing home rate reduction in FY02.

The W&M version also moves Silvercard to DHHS and funding for it is included at $23.2 million.

The net result of the W&M action is that of the $185 million requested to maintain operation of the current program at current eligibility and service levels, they recommended @ $57 million. Therefore, if the W&M version were approved, DHHS

would be faced with a loss of total funds of @ $421 million ($128 million state match; $293 million federal funds). This mandated reduction by the W&M proposal would place South Carolina's Medicaid program perilously close to becoming non-compliant with federal rules and regulations. Under federal rules, state Medicaid programs must cover certain mandatory populations and certain services for those mandatory populations (e.g. hospitalization, physician services, etc.) States may not simply eliminate these mandatory populations or these mandatory services. The reductions mandated by the W&M proposal would require DHHS to severely reduce or eliminate most of the optional services and population groups currently served under the Medicaid program. These include the aged, blind and disabled program, the prescription drug program for the elderly and disabled, the CHIPS program for children, certain optional services such as optometry, podiatry, durable medical equipment, etc., and the community long-term care program. Essentially, South Carolina would be left with a Medicaid program that covers the mandatory populations with services required under federal law and little or no optional features in its program.

The W&M recommendation would also impact Medicaid funding to other state agencies, estimated reduction at $50 - $60 million. These include services at DMH, DDSN, DSS, DHEC, DJJ and school districts.

Provisos

Pharmacy Services

I - Name of Service: Pharmacy Services

II - Description of Service: Pharmacy Services is an optional Medicaid service. The basic objective of the Medicaid Pharmacy program is to provide needed pharmaceuticals for the purpose of saving lives in an emergency or a short term illness, for sustaining life in chronic or long term illness, or for limiting the need for hospitalization. Pharmacy services include most prescriptions drugs and some over-the-counter drugs are covered when prescribed by a doctor. The quantity limit on all prescriptions is no more than a month's supply of medication per prescription or refill. Medicaid also pays for some products only when prescribed for certain medical conditions, so a review process call "prior approval " is utilized. Medicaid does NOT pay for most brand name drugs if there are generic drugs available that can be used.

* Adult recipients are limited to four prescriptions per month (effective 01/01/99). Certain products and product categories are exempt from the monthly prescription limitation

* A prescription limit override is possible for beneficiaries that meet the criteria for acute sickle cell disease, diabetes, hypertension, behavioral health disorder, end stage lung disease, life-threatening illness, cancer, end stage renal disease, organ transplant, cardiac disease (including hyperlipidemia), HIV/AIDS, or the terminal stage of an illness.

* Most adult recipients are required to make a $3.00 co-payment for each prescription or refill. There is no co-payment required for a prescription or refill for children, for nursing home/waiver program patients, for family planning, or for prescriptions related to pregnancy.

*Children, age birth through the month of their 21st birthday, are exempt from the prescription limit and may receive as many prescriptions or refills as needed.

III - Impact:

* The Ways and Means budget will eliminate both the prescription override and the fourth prescription significantly reducing the prescription benefit for adults under Medicaid.

* The Ways and Means budget would mean that the maximum number of prescriptions for an adult would be three per month and the maximum quantity per prescription would be a month's supply.

* The Ways and Means budget may require further reductions in the Pharmacy Services program.

IV – Fiscal Impact:

Action:	State $	Federal $	Total $	Recipients
1) Elimination of the 4th prescription	**$ 7 million**	**$ 16 million**	**$ 23 million**	**110,000**
2) Eliminate prescription override	**$ 15 million**	**$ 34.4 million**	**$ 49.5 million**	**35,332**
3) Eliminate Optional Portion of the Entire Pharmacy Program	**$ 94 million**	**$ 216.6 million**	**$ 311 million**	**289,438**

Medicaid Eligibility Proviso

Description of Current Process and the Changes Required by the Proviso:
This Ways and Means Proviso requires:

1) Prohibition on fax or mail in applications. Instead applicants, family members, or third parties must apply in person with an eligibly worker.

- Approximately 27,000 applications are currently processed via the mail with minimal contact with the applicant
- Elimination of the mail in process will require applicants to visit an application access point (DSS county office, hospital or other site where a Medicaid worker is located) and be interviewed by a caseworker. This will lengthen the application processing time as well as present a barrier to access for some applicants.

Total *cost* generated by elimination of the mail in process: $645,162

2) A "face to face" re-application every six months is required.

- Currently cases are reviewed annually. A large portion are completed by mail.
- There are 479,000 families that will need to have their eligibility reviewed twice as often
- An additional 116,000 cases are Supplemental Security Income. We are required to accept the Social Security Administration's (SSA) decision.
- Families are required to report changes that may affect their eligibility within 10 days of the change.
- Many of those on Medicaid are the working poor with unpaid leave and no employee health insurance benefits. They will need to choose between going to work or spending a significant portion of the day to meet with an eligibility worker regarding their application or renewal of benefits. In some cases, they may need to choose between keeping their job and having health insurance.
- Elderly and disabled citizens who are incapacitated or who reside in an institutional setting will find it difficult if not impossible to apply or renew their Medicaid benefits.
- Those with limited means of transportation will be unable to apply or renew their Medicaid benefits.
- A change in the process would also require additional staff and staff time as the workload would automatically double.

Total *cost* generated by requiring face to face reviews every 6 months: $16,835,656

Note: The Ways and Means recommendation also requires a 4 million dollar cut in eligibility

3) Documented proof of citizenship

- Currently applicants are required to sign a statement that they are US citizens or lawful immigrants and they must provide a social security number.
- If citizenship is questionable, documentation such as a birth certificate is required.
- Only United States citizens and certain non-citizens may be eligible for Medicaid benefits.

- Eligibility for Medicaid benefits for individuals, who are not citizens (i.e., aliens) or nationals of the United States, is based on whether the alien is a qualified or non-qualified alien when the alien entered the United States and whether the alien has 40 Social Security work quarters. United States citizens and certain qualified aliens are eligible for the full range of Medicaid benefits. Non-qualified aliens may be eligible for Medicaid to pay for emergency services only.
- Aliens who are not entitled to full Medicaid benefits may be eligible for emergency services only, if the following conditions exist:

  1) All other eligibility requirements are met except satisfactory immigration status; and,

  2) The care and services needed are not related to an organ transplant procedure or routine prenatal or post-partum care; and,

  3) The alien has, after sudden onset, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; and
  - Serious dysfunction of any bodily organ or part.
  - All labor and delivery is considered emergency labor and delivery

Federal Perspective:

- The Health Care Financing Administration (HCFA)/Centers for Medicare and Medicaid Service (CMS) encourages States to simplify enrollment in and the renewal of Medicaid health insurance benefits. Some examples of this encouragement can be found in:
  - *Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*, CMS Pub. No. 1100, August 2001
  - *Supporting Families in Transition-A Guide to Expanding Health Coverage in the Post-Welfare Reform World,* HCFA Publication on hcfa.gov/Medicaid web site
  - January 19, 2001 State Medicaid Director letter from HCFA.
  - September 10, 1998 Dear State Health Official letter from HCFA
- No federal or state study has found South Carolina's Medicaid program with a substantial error rate.
- In HCFA's May 8, 2001 letter to the SC Dept of Health and Human Services, South Carolina was commended for:
  - Having one of the most successful SCHIP outreach efforts in the country and development of a simplified application which is placed in provider offices and schools
  - Coordinating TANF/Food Stamp and Medicaid reviews and utilizing a Medicaid quarterly mail in review
- Federal law requires that Medicaid eligibility be determined in a manner consistent with simplicity of administration and in the best interest of recipients (Section 1902 (a)(4) and (19) of the Social Security Act). Any changes which are inconsistent with this requirement may not be approved by the federal government.

Citizenship/Alienage

The facts are:

- Under Federal law and regulations, US citizens and certain non-citizens may be eligible for the full range of Medicaid benefits.
- Eligibility for individuals, who are not citizens (i.e., aliens), is based on whether the alien qualified when entering the US and worked 3 calendar months as defined by the Social Security Act .
- Aliens who are not entitled to full Medicaid benefits may be eligible for emergency services only (life threatening or labor and delivery).
- Alien groups such as foreign students, visitors, tourists, foreign government representatives on official business, crewmen on shore leave, international organization representatives, temporary workers, members of the foreign press, radio, film, etc. and their families and short term parolees are not eligible for any services (including emergency services).
- The SC Medicaid Policy Manual accepts the applicant's declaration of citizenship as verification unless questionable. Verification of alienage for non-citizens is required as well as the Systematic Alien Verification for Entitlement (SAVE) through INS.

Documentation standards:

- Federal regulations (CFR435.913) require that states must include in each case record facts to support the agency's decision.
- The State Medicaid Manual does require documentation and verification, as well as the applicant's declaration of citizenship or alien status.
- Federal rules provide States with flexibility to simplify application processes that create barriers to enrollment and has encouraged states to accept applicant declaration, except for alienage and SSNs.
- DHHS saw requiring proof of citizenship could create a significant barrier to enrollment, as well as a significant administrative burden.
- The preamble to the final SCHIP regulations permit states to accept self-declaration of citizenship, provided that they have implemented effective, fair and nondiscriminatory procedures for ensuring the integrity of their application process with respect to self-declaration of citizenship.

  The Social Security Administration determines eligibility for SSI recipients, who automatically qualify for Medicaid, under their own documentation standards.

Yearly Income Limits
Family Related Poverty Level Groups

Family Size	PERCENT OF FEDERAL POVERTY LEVEL				
	50%	100%	133%	150%	185%
	Coverage Groups				
	LOW INCOME FAMILIES (LIF) RIBICOFF *(mandatory)*	CHILDREN AGES 6-18 *(mandatory)*	CHILDREN AGES 1-6 *(mandatory)*	Partners for Healthy Children *(optional)*	PREGNANT WOMEN/ INFANTS *(mandatory)*
3	$7,308	$15,020	$19,977	$22,530	$27,787

NOTE: Note income limits shown are amounts after disregards and deductions allowed by the Medicaid program.

Elderly and Disabled Related Poverty Level Groups

Family Size	PERCENT OF FEDERAL POVERTY LEVEL				
	100%	135%	175%	200%	250%
	Coverage Groups				
	AGED, BLIND DISABLED *(optional)* QUALIFIED MEDICARE BENEFICIARIES *(mandatory)*	SPECIFIED LOW INCOME MEDICARE BENEFICIARIES *(mandatory)*	SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB) (QI-1&QI-2) *(mandatory)*	QUALIFIED WORKING DISABLED INDIVIDUALS *(mandatory)*	WORKING DISABLED *(optional)*
1	$8,860	$11,961	$15,505	$17,720	$22,150

Optional Coverage Groups which may have to be eliminated

Elimination of Optional Medicaid Eligibility Coverage Groups

Name of Coverage Group: Child Health Insurance Program (CHIP)

Description of Coverage Group:

- This is an optional Medicaid coverage group
- These are children ages 1-5 in families with income between 133% and 150% of the poverty level and children ages 6-18 in families with income between 100% and 150% of the poverty level.
- For a family of 3, the annual income is up to $22,530 (i.e. 150% of federal poverty level).
- There is 80% federal funding and 20% state funding

Impact on Children: 42,000 children will lose their Medicaid health insurance

- Children will not have access to basic health care such as dentists, doctors, pharmaceutical products and hospital care. Instead they will access the emergency room for acute care.

Fiscal Impact on Providers: Providers will lose $36,993,944 in Medicaid revenue.

- Hospitals: $8,522,031
- Physicians: 6,227,959
- Clinical Services: 1,802,735
- Managed Care: 710,635
- Dental: 8,831,890
- Pharmacies: 7,980,382
- Medical Professional: 970,516
- Other Providers: 1,947,796

Fiscal Impact on State Agencies: State agencies will lose $6,062,452 in Federal funds.

- DMH: $2,648,157
- DOE: 1,130,452
- DHEC: 554,361
- Other Agencies: 1,729,482

Fiscal/General Impact on the State:

- The state will lose $35,657,607 in federal funds.

Elimination of Optional Medicaid Eligibility Coverage Groups

Name of Coverage Group: Aged, Blind and Disabled

Description of Coverage Group:

- This is an optional Medicaid coverage group
- These are disabled, blind and elderly citizens with incomes up to 100% of the poverty level. ($8,860/year for an individual and $11,940/year for a couple)
- Their resources must be below $4,000 for an individual or $6,000 for a couple.

Impact on the Disabled, Blind and Elderly Citizens: 45,828 citizens will lose their Medicaid health insurance

- The primary service this group receives through Medicaid is prescription drugs.
- Without Medicaid coverage, this group would likely displace the current 40,000 Silver Card recipients.
- While a portion of these have Medicare, 17,000 eligibles do not have Medicare and will lose all health care insurance. Without coverage for basic health care, the disabled citizens may be in danger of needing institutional care.

Fiscal Impact on Providers: Providers will lose $221,598,437 in Medicaid revenue.

- Hospitals: $68,027,411
- Nursing Homes: 18,012,158
- Physicians: 16,513,110
- Home Health: 1,329,881
- Lab & X-Ray: 883,846
- Clinical Services: 5,923,782
- Dental: 1,513,135
- Transportation: 1,845,223
- Pharmacies: 88,754,378
- CLTC: 12,305,602
- Durable Medical Equipment: 5,315,116
- Other Providers: 1,174,795

Fiscal Impact on State Agencies: State agencies will lose $29,066,667 in Federal funds.

- DDSN: $21,547,420
- DMH: 5,623,974
- MUSC: 762,154
- DSS: 595,949
- Other agencies: 537,181

Fiscal/General Impact on the State:

- **The State will lose $183,498,617 in Federal funds**
- Without adequate primary care and drug coverage, many of these citizens would need institutional care provided by the State with all state dollars.

Elimination of Optional Medicaid Eligibility Coverage Groups

Name of Coverage Group: Working Disabled

Description of Coverage Group:

- This is an optional Medicaid coverage group
- These are permanently and totally disabled citizens with incomes up to 250% of the poverty level, which are $22,150 per year for a family of one and $29,850 per year for a family of two.
- Most were eligible for Medicaid based on disability before they became employed and this option allows them to enter the work force and keep Medicaid coverage as long as their income does not exceed the above amounts.
- A typical example is a quadriplegic who is able to be gainfully employed with adequate support.

Impact on Disabled Citizens: 100 disabled working adults will lose their Medicaid health insurance

- Many of these individuals require daily attendant care to perform such functions as toileting, bathing, dressing and feeding functions. With their Medicaid coverage, they can be employed and sometimes be covered by private insurance. However, insurance does not typically cover attendant care. If these disabled persons must pay for attendant care, they would not have enough earned income left to pay for food, housing and other normal living expenses.

Fiscal Impact on Providers: Providers, primarily pharmacies, will lose $472,295 in Medicaid revenue.

Fiscal Impact on State Agencies: State agencies, primarily DDSN, will lose $228,234 in Federal funds.

Fiscal/General Impact on the State: The State will lose $557,376 in federal funds

- Without working disabled coverage, these citizens will be at risk of losing the support systems that allow them to work. They would then remain dependent on government aid for all health care and living support. Eliminating this coverage would cost the State more to support these disabled citizens. For example, if these individuals lose their jobs due to lack of attendant care, they would most likely be unable to pay for their private health insurance, which would mean that Medicaid would be the primary (as opposed to secondary) payer for medical care.

Elimination of Optional Medicaid Eligibility Coverage Groups

Name of Coverage Group: Foster Care

Description of Coverage Group:

- This is an optional Medicaid coverage group
- These are children under 21 who live in foster homes or group homes and are under state custody. The State is responsible for all of their care including medical services.

Impact on Children: 1,300 foster children will lose their Medicaid health insurance

Fiscal Impact on Providers: Providers will lose $625,378 in Medicaid revenue.

Fiscal Impact on State Agencies: State agencies will lose $7,042,154 in Federal funds.

- DMH: $894,105
- DSS: 4,917,294
- DJJ: 378,545
- Other Agencies: 762,210

Fiscal/General Impact on the State:

- **The State will lose $7,477,980 in Federal funds**
- If Medicaid coverage is not provided, the State must pay for their medical care with 100% state dollars. Elimination of this group results in a significant cost to the State. For every $1 South Carolina now spends on this group, it would have to pay an additional $0.70 if Medicaid coverage is eliminated.

Elimination of Optional Medicaid Eligibility Coverage Groups

Name of Coverage Group: Breast and Cervical Cancer

Description of Coverage Group:

- This is an optional Medicaid coverage group.

- These are uninsured women who have been screened through the Center for Disease Control (CDC) program for breast or cervical cancer. In South Carolina, DHEC administers the screening program and it is called the Best Chance Network. While CDC provides funding for screening, no funding was available for treatment prior to this Medicaid coverage group.

- This eligibility group was established by Congress in FFY 2001 and included an enhanced match rate (80/20) as an incentive for states to implement the program.

Impact on Women: Forty uninsured women will lose their Medicaid coverage for their cancer treatment.

Fiscal Impact on Providers: Providers will lose $286,312 in Medicaid revenue.

- Hospitals: $119,168
- Physicians: 141,014
- Other Providers: 26,130

Fiscal Impact on State Agencies: No significant impact on state agencies.

Fiscal/General Impact on the State:

- **The State will lose $199,531 in Federal funds**.

Elimination of Optional Medicaid Eligibility Coverage Groups

Name of Coverage Group: Katie Beckett (TEFRA)

Description of Coverage Group:

- This is an optional coverage group.
- These are severely and permanently disabled children who need at least intermediate nursing home or hospital care for an extended period but have family members who are willing to care for them at home. An example is a child who is ventilator dependent requiring around the clock care.
- Parents' income is not considered. The child's income must be at or below the Medicaid Cap of $1,635 per month. The Medicaid Cap is equal to 300 percent of the current SSI Federal Benefit Rate (FBR) for an individual.

Impact on Severely Disabled Children: 2,100 disabled children will lose their Medicaid health insurance.

- Many of these families have exhausted their lifetime maximum benefit for their private health insurance or cannot obtain private coverage and Medicaid is their last resort.
- Without Medicaid coverage, the extraordinary cost of care can cause entire families to become financially unstable and are subject to stress related problems that negatively affect their health and well-being.

- **Fiscal Impact on Providers: Providers will lose $7,895,734 in Medicaid revenue.**
  - Hospitals: $1,879,478
  - Physicians: 637,570
  - Pharmacies: 2,967,575
  - Durable Medical Equipment: 891,916
  - CLTC: 426,718
  - Other Providers: 1,092,477

Fiscal Impact on State Agencies: State agencies will lose $4,601,245 in Federal funds.

- DDSN: $2,516,825
- DOE: 1,084,675
- Other Agencies: 999,745

Fiscal/General Impact on the State:

- Elimination of this group will put pressure on the State to enhance access to institutional care for these children.
- **The State will lose $10,103,782 in Federal funds**.

Elimination of Optional Medicaid Eligibility Coverage Groups

Name of Coverage Group: Optional State Supplementation

Description of Coverage Group:

- This is an optional coverage group.
- These are people who have income up to $10,716 per year and who live in a residential care facility. They do not have income to pay for a living arrangement and do not usually have a strong family support system.

Impact on Citizens:

- **1,700 citizens will lose their Medicaid health insurance**
- Many of these citizens have moved out of mental health institutions or have developmental disabilities. Without this program, they will be displaced and create greater need for more state run institutions.

Fiscal Impact on Providers: Providers will lose $11,171,340 in Medicaid revenue.

- Hospitals: $2,477,490
- Nursing Homes: 862,568
- Physicians: 524,023
- Pharmacies: 5,993,181
- CLTC: 395,909
- Other Providers: 918,169

Fiscal Impact on State Agencies: State agencies will lose $13,770,426 in Federal funds.

- DDSN: $2,174,736
- DMH: 11,159,488
- Other Agencies: 436,202

Fiscal/General Impact on the State:

- State agencies, primarily the Department of Mental Health and the Department of Disabilities and Special Needs will need to open more institutional beds or residential programs.
- **The State will lose $21,555,733 in Federal funds.**

Optional Services which may have to be reduced/eliminated

Elimination of the Hospice Service

Name of Service: Hospice

Description of Service: Hospice is an optional Medicaid service provided to terminally ill recipients with a life expectancy projection of 6 months or less. The hospice package of services includes physician services, nursing services, personal care aide, medical equipment, counseling, certain prescriptive medications specifically pain management medications related to the terminal illness, and bereavement services.

Impact on Beneficiaries:

- Annual average number of recipients serviced: 220
- Average number of days in hospice care for SC Medicaid - 27

Fiscal Impact:

- State Savings - $970,000
- Federal Dollars Lost – $1.2 M
- Total - $3.2 M

A daily all-inclusive rate is paid regardless of service intensity.

General Impact on State: If the hospice service is eliminated, the cost of care for the Medicaid recipients would are enrolled or who become terminally ill would be spread across the budget lines for home health, hospital, pharmacy, and physician services and would be most costly to the Medicaid program.

Home and Community Based Services

Name of Service: Community Long Term Care (CLTC) Home and Community-Based Services

Description of Services: CLTC is an optional Medicaid program which provides home and community-based services to persons who would otherwise require nursing home care. These programs build on existing family supports through the provision of such services as home delivered meals, adult day care and hands-on personal care. There are four different programs serving the following populations: frail elderly and disabled adults; persons of all ages with HIV/AIDS; adults requiring ventilator care; and medically fragile children in need of in-home hands on assistance.

Impact on Beneficiaries:

- Annually, 16,000 Medicaid recipients receive services through one of these programs.
- Recipients must meet the same medical criteria for Medicaid sponsored nursing home care as nursing home patients.
- There are over 3,500 applicants on a waiting list for the CLTC.

Fiscal Impact:

- State saves by elimination of CLTC program $24.5 million.
- **Federal dollars lost are approximately $56.2 million.**
- Total cost of program $80.7 million
- The state savings will not be as great if persons in CLTC programs enter nursing homes. Since CLTC costs to Medicaid are approximately 42% of the cost of nursing home care, erode state savings.

General Impact on State: The Supreme Court Olmstead decision affirmed the right of disabled persons to receive care in the community. The South Carolina Olmstead Task Force recently recommended increases in home and community-based options. Since there is already near a six month wait for some CLTC applicants, any reductions could lead to lawsuits based upon the Olmstead decision.

Elimination of Optional Programs

Name of Service: Durable Medical Equipment (DME)

Service Description: DME is an optional service which provides medical equipment, supplies, (a methods by which life-sustaining nutrition is given to patients who cannot take food by mouth (hyper-alimentation); devices that correct or prevent skeletal deformities (orthotics), and appliances that replace all or part of the function of an inoperative/malfunctioning organ (prosthetics).

Durable medical equipment and supplies must be prescribed by a licensed physician. The prescription is filled by a DME supplier who is enrolled in the Medicaid program. The Department of Health and Human Services must prior approve certain DME and supplies**.**

Beneficiaries Impact

- **79,692 citizens will lose Medicaid sponsored DME and supplies** which improve the functioning of malformed/malfunctioning organ or body parts (e.g. replacements for amputated limbs).

- Reduction or elimination of this service would negatively affect the health, mobility and independent functioning of the person who receives the services.

- Consequently, the individual's ability to work or live independently may be reduced or eliminated.

- Loss of these services will result in increased hospitalizations or other institutional care.

- **$51.6M in provider payments for DME services will be lost by the state.**

- **The state will lose $35.9M in federal dollars with elimination of this program.**

Elimination of Optional Medical Professional Services

Various Medical Professionals provide a myriad of services. Only Certified Nurse Practitioners and Certified Nurse Midwives are mandatory services in this category. Some of the optional services that could be eliminated include:

Chiropractic Program: Optional Chiropractic services are $575,000. Elimination of these services will result in a loss of $400,000 in federal funds to the state.

Optician and Optometry services: Optional Optometry services are $855,000. The elimination of these services will result in a loss of $595,000 in federal funds to the state.

Podiatry Services: Optional Podiatry services are $420,545. The elimination of these services will result in a loss of $293,000 in federal funds to the state.

Private Rehabilitation Therapy Services (e.g. physical therapy, speech therapy): Optional Private Rehabilitation Services for children under 21 are $5,863,000. The state match amount for these services is shared between DHHS, DHEC, DOE and DDSN. Elimination of these services will result in a loss of $4,558,000 in federal funds to the state.

Other General Information

Medicaid
3-Year Appropriation History & FY 2002-03 Budget Request

	FY 1999-00 Appropriation	FY 2000-01 Appropriation	FY 2001-02 Appropriation	FY 2002-03 Budget Request
Medical Contracts	**$ 13,346,361**	**$ 13,658,784**	**$ 14,975,080**	**$ 14,975,080**
Medical Assistance				
HOSPITAL SERVICES	104,914,518	104,781,162	116,665,048	116,665,048
NURSING HOME	88,521,845	86,951,769	96,783,751	96,783,751
DISPR. SHARE	-	20,023,664	21,292,776	21,292,776
PHARM. SERVICES	46,962,677	47,153,331	60,459,523	60,459,523
PHYSICIAN SERVICES	32,087,481	32,124,721	44,499,825	44,499,825
DENTAL SERVICES	6,889,966	5,119,491	5,672,320	5,672,320
COMM. LONG TERM CARE	16,705,832	18,517,282	20,456,544	20,456,544
OTHER MEDICAID SERV.	18,334,218	15,860,953	22,074,356	22,074,356
FAMILY PLANNING	1,046,477	1,046,510	1,046,955	1,046,955
SMI - REGULAR	16,627,798	16,654,730	16,684,836	16,684,836
SMI - MAO	4,218,919	4,224,901	4,224,901	4,224,901
HOSPICE PROGRAM	909,777	910,012	938,164	938,164
RESIDENTIAL CARE FACIL.	13,884,753	13,929,766	14,186,296	14,186,296
ASSISTED LIVING	500,000	500,000	500,000	500,000
CHILD HEALTH INSURANCE	2,000,000	2,189,054	4,996,588	4,996,588
CLINICAL SERVICES	13,170,097	13,545,298	14,964,076	14,964,076
DURABLE MEDICAL EQUIP.	9,733,179	9,738,545	10,441,361	10,441,361
Subtotal	**$ 376,507,537**	**$ 393,271,189**	**$ 455,887,320**	**$ 455,887,320**
Total Recurring Funds	**$ 389,853,898**	**$ 406,929,973**	**$ 470,862,400**	**$ 470,862,400**
Non-Recurring				
Supplemental	56,021,616	49,800,437	0	0
Tobacco Settlement	0	140,147,185	0	0
Tobacco Carry-Forward	0	0	20,000,000	20,000,000
Medicaid Maximization (8.52)	0	0	110,000,000	110,000,000
Non-Recurring Approp.	0	0	8,466,386	8,466,386
Subtotal	**56,021,616**	**189,947,622**	**138,466,386**	**138,466,386***
Total Medicaid Approp.	**445,875,514**	**596,877,595**	**609,328,786**	**609,328,786**

FY 2002-03 Request (Growth & Other Annualizations Only)	
FY 02 Client Growth Annualization	7,250,000
Pharmacy AWP Annualization	2,420,800
Client Growth for FY 03	25,246,814
Product Growth for FY 03	12,500,000
Subtotal	**$ 47,417,614***
Total FY 03 Budget Request	**$ 656,746,400**

Notes:
Disproportionate Share funds transferred to HHS from MUSC in FY 2000-01.
Proviso 8.49 of FY 02 Approp. Act increased Hospital Tax by $10 Million for that Fiscal Year.
* These amounts equal our budget request of $185,884,000.

Economic Impact of Medicaid on South Carolina[1]

- Medicaid is a component of SC's $7.4 billion health care industry.
- Medicaid generates 94,200 jobs or about 5 % of state's employment base.
- The health care industry supported 131,400 related jobs in 2000.
- Medicaid imports billions of federal matching dollars into the state's economy.
- A 5.27 % increase, or $47 million additional state dollars, brings in $109.7 million federal matching dollars and generates 3,250 more jobs and $79 million in income for South Carolinians.
- Federal dollars create 61,000 jobs and $1.5 billion in income.
- Medicaid has a direct economic impact on hospitals, nursing homes, other health care services.
- Medicaid dollars have a ripple effect and an indirect effect, such as: health care employees spend part of their salaries on automobiles, which leads auto dealer employees to spend part of their salaries on groceries, and so on.
- A **reduction** in state spending on Medicaid has serious economic implications and will have a substantial impact on the state's economy.
    - Loss of federal Medicaid matching payments, currently estimated at $360 million.
    - 10,755 (estimated) jobs will be lost as a result of a decline in federal spending in SC.
    - $261.9 million in federal dollars (income) lost as a result of reduced state match.
    - If the match is reduced by $362 million, it would represent a decline in federal spending of over 17% from the current baseline of $2.1 billion.

3/5/02

[1] Research by Darla Moore School of Business, USC

The Economic Impact of Lost Federal Medicaid Spending on the State of South Carolina[2]

Medicaid expenditures in South Carolina have significant positive economic impacts. Specifically, the Federal Medicaid match supports more than 61,000 jobs in the state, and generates more than $1.5 billion in income for South Carolinians. Importantly, these impacts are felt across the state, in both urban and rural areas.[3] These impacts are generated solely by the direct and ripple effects stemming from the Federal portion of Medicaid spending.

State spending on Medicaid is therefore an important ingredient in South Carolina's economic development. Changes in state Medicaid spending will have an amplified impact on the amount of Federal matching dollars, and can thus have substantial impacts on the state's economy. The model used by the Division of Research at the Moore School of Business to estimate the overall impacts of Federal Medicaid spending can also be used to estimate the economic effects of changes in Medicaid expenditures.

Currently, there is the possibility that South Carolina will see its Federal Medicaid match drop by approximately $362 million. This represents a decline in Federal spending of over 17 percent from the current baseline figure of $2.1 billion. This decline in Federal spending can be expected to have a large negative impact on the state's economy. This estimated impact is given in Table 1.

Table 1. Economic Impacts of Medicaid, Current and Potential Loss

	Supported by current Federal spending	Estimated losses from a $362 million decline in Federal spending
Jobs	61,807	10,755
Income ($millions)	1,505.0	261.9

In South Carolina, as across the nation, budget writers are faced with another year of difficult decisions that highlight the economic concept of *opportunity cost* – the value of what must be given up as scarce resources are allocated towards a competing end. This summary provides South Carolina's policymakers with a quantifiable look at the opportunity cost of a decline in Federal Medicaid dollars – the loss of jobs and income across the state.

---

[2] Prepared by the Division of Research, Moore School of Business, the University of South Carolina.

[3] These results, further discussion of the results, and the methodology used to derive the results are available in the full report, "Economic Impact of Medicaid on South Carolina", developed by researchers at the Division of Research for the South Carolina Department of Health and Human Services. This report is currently available from a link at the Division of Research's website: http://research.moore.sc.edu, or directly from the DHHS website: http://www.dhhs.state.sc.us.

County-level breakdown of job and income losses due to a $362 million reduction in Federal Medicaid spending

County	Jobs	Income
ABBEVILLE	74	$1,775,496
AIKEN	249	$6,043,965
ALLENDALE	31	$553,401
ANDERSON	387	$9,862,922
BAMBERG	65	$1,143,873
BARNWELL	88	$1,312,730
BEAUFORT	128	$3,942,248
BERKELEY	124	$2,046,367
CALHOUN	38	$592,291
CHARLESTON	1223	$34,895,726
CHEROKEE	95	$1,909,316
CHESTER	56	$1,238,349
CHESTERFIELD	111	$1,898,302
CLARENDON	92	$2,012,158
COLLETON	122	$2,458,225
DARLINGTON	248	$4,372,630
DILLON	101	$1,997,246
DORCHESTER	221	$3,984,958
EDGEFIELD	33	$520,789
FAIRFIELD	60	$1,120,760
FLORENCE	687	$16,864,217
GEORGETOWN	157	$3,929,040
GREENVILLE	865	$23,752,979
GREENWOOD	171	$5,170,735
HAMPTON	46	$805,312
HORRY	360	$8,477,760
JASPER	22	$641,494
KERSHAW	86	$1,841,264
LANCASTER	129	$2,923,642
LAURENS	288	$5,248,427
LEE	45	$733,048
LEXINGTON	372	$8,257,109
MCCORMICK	36	$427,790
MARION	102	$2,830,323
MARLBORO	70	$1,468,639
NEWBERRY	86	$1,439,335
OCONEE	96	$2,231,663
ORANGEBURG	250	$6,320,244
PICKENS	166	$3,228,456
RICHLAND	1946	$51,928,293
SALUDA	42	$543,162
SPARTANBURG	555	$14,664,323
SUMTER	242	$5,732,676
UNION	68	$1,058,247
WILLIAMSBURG	82	$1,642,722
YORK	239	$6,045,141
TOTAL	10755	$261,887,795

State Employee Health Insurance vs. Medicaid Health Coverage

A Cost Comparison

The following is a comparison to the state of cost in state appropriated dollars for a child to be covered by the state employees program and the Medicaid program.

Per child cost – state dollars

State Health Insurance	$32.41	per month
Regular Medicaid	$27	per month
CHIP	$14	per month

Most children of state employees who are Medicaid eligible are eligible under the CHIP program. For each of these children who do not enroll in the State Employees Health Plan and do enroll in Medicaid, the state saves $18.41 per month or $220 per year.

In October 2001, 3,451 dependents had shifted from the State Employees Plan to Medicaid. This represented a reduction in net state expenditures of $759,220 per year